



Provider Enrollment

New Individual/Sole Proprietor Provider

“Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time.”

-Provider Relations

Table of Contents

- Register for MILogin and CHAMPS [Slides 3-16](#)
- New Provider Enrollment [Slides 17-92](#)
- Track Existing Application [Slides 93-97](#)

Register for MILogin and CHAMPS

MILogin is a website that allows a user to enter one ID and password in order to access multiple applications.

CHAMPS (Community Health Automated Medicaid Processing System) is the program where providers enroll, update enrollment information, and report services provided.

MILogin for Third Party

User ID

Password

Password

LOGIN

Don't have an account?

SIGN UP

Forgot your User ID?

Forgot your password?

Need Help?

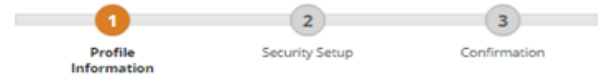
Copyright 2015-2019 State of Michigan

- Open your web browser (e.g. Internet Explorer, Google Chrome, Mozilla Firefox, etc.)
- Enter <https://milogintp.Michigan.gov> into the search bar
- Click Sign Up

MILogin for Third Party

[HOME](#)

Create Your Account



Profile Information

Enter your profile information

* Required

*First Name

Middle Initial

*Last Name

Suffix

*Email Address

*Confirm Email Address

*Work Phone Number

Mobile Number

*Verification Question: Bee, chin, ankle, leg and dog: how many body parts in the list?

☐

agree to the [terms & conditions](#).

NEXT

RESET

- Complete all required fields
- Check the 'I agree' box
- Click Next

MILogin for Third Party

HOME

Create Your Account



Security Setup

Provide user id and password information to complete your profile

* Required

* User ID

Enter a User ID

* Password

Enter password

* Confirm New Password

Confirm password

* Security Options

To choose your preferred password recovery method(s), please click on the buttons below. Multiple options can be selected.



CREATE ACCOUNT

BACK



User ID guideline:

- Enter your last name, first initial, and any 4 numbers with no space between them. For Example: John Smith and using 9999 as an example for the four digit number, you would enter smithj9999.

Password Guidelines:

- Must be at least 8 characters in length
- Must include characters from 3 of the following categories:
 - Upper case letters (A-Z)
 - Lower case letter (a-z)
 - Numbers (0-9)
 - Special characters (IS#,%@~^&*_-+=><)
- Should not be one of the last 3 used passwords
- Should not be based on your User ID

- Create the user ID and password following the listed guidelines
- Select the preferred password recovery method(s)
- Click Create Account

MILogin for Third Party

[HOME](#)

Create your account



Confirmation

✓ Success

Your account has been successfully created.

[LOGIN](#)

- Your MILogin account has now been created successfully
- Click the Login button to return to the login screen

MILogin for Third Party

User ID

Password

Password

LOGIN

Don't have an account?

SIGN UP

Forgot your User ID?

Forgot your password?

Need Help?

Copyright 2015-2019 State of Michigan

- Enter your User ID and Password you just created
- Click Login

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Home Page

⌚ Your password will expire in **364** days

Access your applications by clicking on the application links below

You do not have access to any application. You can request access by clicking on [Request Access](#) link.

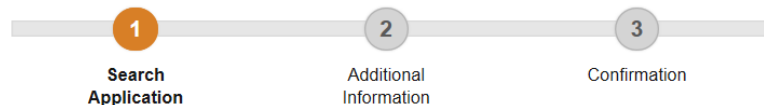
- Your Home Page will not show any applications
- Click Request Access

**MILogin resource links are listed at the bottom of the page*

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Request Access



Search Application

Search for an application with a keyword or select an agency to view its applications

- Type CHAMPS in the search box
- Click the search/magnifying button

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Request Access

1

Search
Application

2

Additional
Information

3

Confirmation

Search Application

Search for an application with a keyword or select an agency to view its applications

**Michigan Department of Health & Human Services (MDHHS)****CHAMPS**

- Click on CHAMPS

MILogin for Third Party

HOME

Request A


Search App

Search for an application

CHAMPS

MDHHS Michigan

CHAMPS



CHAMPS

(Community Health Automated Medicaid Processing System) is the Michigan Medicaid Management Information System (MMIS). It supports Medicaid provider enrollment and maintenance, beneficiary healthcare eligibility and enrollment, prior authorization, Home Help Electronic Service Verification (ESV), fee-for-service payments and managed care enrollments, payments, and encounters.

General laws, rules and regulations. The systems are intended for use only by authorized persons and only for official state business. Systems users are prohibited from using any assigned or entrusted access control mechanisms for any purposes other than those required to perform authorized data exchange with MDHHS. Logon IDs and passwords are never to be shared. Systems users must not disclose any confidential, restricted or sensitive data to unauthorized persons. Systems users will only access information on the systems for which they have authorization. Systems users will not use MDHHS systems for commercial or partisan political purposes. Following industry standards, systems users must securely maintain any information downloaded, printed, or removed in any format from the systems. When no longer needed, this information must be destroyed in an appropriate manner specific to the format type. All users of the systems give their expressed consent to the monitoring of their activities on the systems. If such monitoring reveals possible evidence of unauthorized or criminal activity, the evidence may be provided to administrative or law enforcement officials for disciplinary action and/or

☒ I agree to the terms & conditions

☐ I do not agree

CANCEL ✕

REQUEST ACCESS

- Select the 'I agree to the terms & conditions' radio button
- Click Request Access

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Request Access

1

✓ Search
Application

2

Additional
Information

3

Confirmation

Additional Information

Provide following information to submit your access request

* Required

*Email Address

*Work Phone Number

*CHAMPS User Type

- ☒ Provider/Other
☐ State User Only

SUBMIT**RESET**

- Verify all information is correct
- Click Submit

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Request Access

1

✓ Search
Application

2

✓ Additional
Information

3

Confirmation

Confirmation

✓ Success

The request for your access has been successfully submitted.

You will see the updated list of application(s) on your home page once it is processed.


[HOME](#)

- You will be given confirmation that your request has been submitted successfully
- Click the Home button to return to the MILogin Home Page

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Home Page

 Your password will expire in **48** days

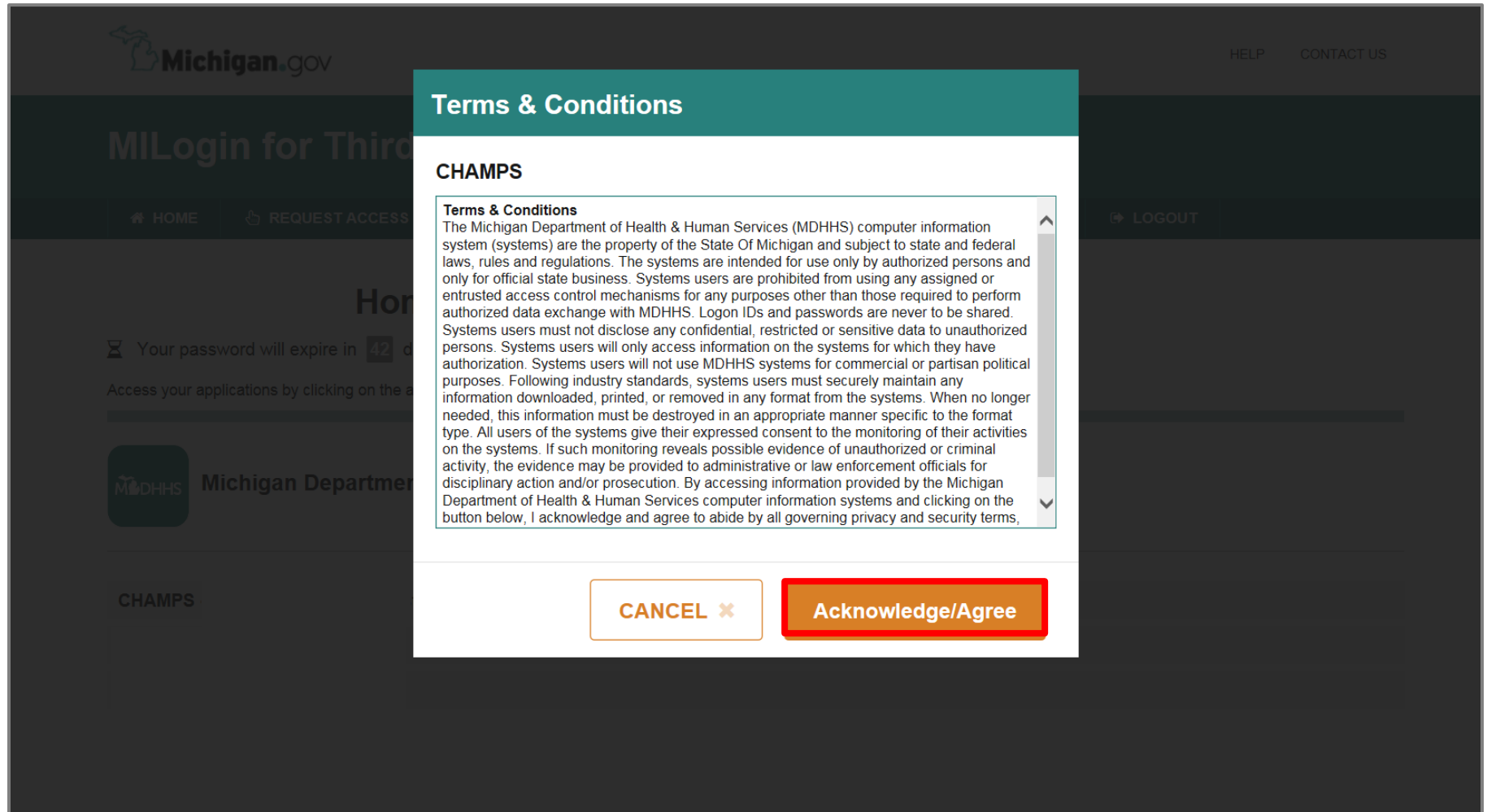
Access your applications by clicking on the application links below



Michigan Department of Health & Human Services (MDHHS)

CHAMPS

- You will be directed back to your MILogin Home Page
- Click the CHAMPS hyperlink



- Click Acknowledge/Agree button to accept the Terms & Conditions to get into CHAMPS

New Provider Enrollment

Steps on how to complete a new CHAMPS enrollment for a Individual/Sole Proprietor Provider type

Prior to enrolling in CHAMPS

- Individual/Sole providers will want to ensure they are enrolled in SIGMA VSS prior to enrolling within CHAMPS.
 - SIGMA VSS website: www.michigan.gov/SIGMAVSS
 - If you have questions regarding this current process, contact the Vendor Support Call Center at 1-888-734-9749 or email SIGMA-Vendor@Michigan.gov
 - After completing SIGMA registration allow 3-5 business days to begin and complete the CHAMPS application. If you attempt to enroll in CHAMPS during this time you may get an error when validating your information.
- Individual/Sole providers must also be licensed prior to enrolling in CHAMPS
 - LARA: <http://www.michigan.gov/lara/0,4601,7-154-72600---,00.html>



Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help



Provider Enrollment



[New Enrollment](#)

Enroll As A New Provider

[Track Application](#)

Track Existing Provider Application

- Click New Enrollment



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment



Enrollment Type



Select the Applicable Enrollment Type

☒ Individual/Sole Proprietor

☒ Regular Individual/Sole Proprietor or Rendering/Servicing Provider



☐ Group Practice (Corporation, Partnership, LLC, etc.)

☐ Billing Agent

☐ Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)

☐ Atypical (non-medical) provider (Choose this option if you do not have a NPI)

☐ Individual (Driver, Home Help/Personal Care, Carpenter, etc.)

☐ Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)



Submit

- Select Regular Individual/Sole Proprietor
- Click Submit

Basic Information 1 - Google Chrome
tp-chp-uat.state.mi.us/ecams/CNSIControlServlet

Print Help

Basic Information: Enter required fields and click Confirm button.

Basic Information

EIN/TIN:

First Name: *

Last Name: *

Suffix:

SSN: *

Date of Birth: *

Middle Initial:

Gender:

Vendor ID: *

Applicant Type: Individual/Sole Proprietor *

Medicare Cost Share: ☐

NPI: *

Contact Email Address:

Email-1: * Email-2:

Email-3: Email-4:

Email-5: Email-6:

Home Address

Please ensure you are providing the home address of this provider. Failure to do so may result in this application/modification being denied.

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: OTHER *

State/Province: OTHER *

County: OTHER *

Country: UNITED STATES *

Zip Code: * -

Validate Address

Confirm Finish Cancel

Page ID: pgN Page ID: dlgAddBasicInformationStep1(Provider) 18:09

- Confirm Applicant Type: Individual/Sole Proprietor
- Provider/Owner information needing to enroll:
 - Basic Information: Fill in all fields marked with an asterisk (*)
 - Home Address: Fill in Address Line 1 and Zip Code, Click Validate Address
(Please Note: you should receive "Address Validation Successful")
- Click Confirm, Click Finish

CHAMPS My Inbox Provider

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20171115618358 Name: Tester,Test

Basic Information

You have successfully completed the basic information on the Enrollment Application.

Your Application ID is: **20171115618358**

Please make note of this Application ID. This is the number you will be required to use to track the status of your enrollment application. Without this number, you will not be able to access your application and your information will be deleted.

Please make sure to complete your application and submit it for State Review within 30 calendar days OR your application will be deleted.

✓ Ok

Page ID: dlgAddBasicInformationStep3(Provider)

- Confirmation, Basic Information is complete
- Take note of the Application ID, as this is used to track your application status
- Click Ok



Application ID: 20171115618358

Name: Tester, Test

Close

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/15/2017	11/15/2017	Complete	
Step 2: Add Locations	Required			Incomplete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 5: Add License/Certification/Other	Optional			Incomplete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Associate MCO Plan	Optional			Incomplete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Go Page Count SaveToXLS

Viewing Page: 1

First Prev Next Last

- Individual Provider Enrollment steps are listed (Please Note: some steps are required versus optional)
- Step 1 has a status of Complete
- Click on Step 2: Add Locations



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Add

To add/modify Pay To, Correspondence and Remittance Advice addresses, click on Location Type hyperlink



Locations List



Filter By



Go

Save Filters

My Filters ▾

Doing Business As

Location Type

Location Details

End Date



No Records Found !

- Click Add, to enter Primary Location information

https://milogin.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20171115618358 Name: Tester, Test

For all locations, Correspondence address is required. For Primary Practice Location, Pay-To address is required. Enter Remittance Advice address only to receive a paper Remittance Advice.

Add Provider Location

Location Type: Primary Practice Location *

Doing Business As: End Date:

If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWER 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: OTHER *

State/Province: OTHER *

County: OTHER

Country: UNITED STATES *

Zip Code: * - **Validate Address**

Phone Number: * Extn:

Fax Number:

Email Address:

Web Page:

Communication Preference:

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:		AM		AM	Thursday:		AM		AM
Monday:		PM		PM	Friday:		AM		AM
Tuesday:		PM		PM	Saturday:		PM		PM
Wednesday:		PM		PM					

Accepting New Clients:

Offers OB-Gyn Services:

Handicap Accessible: No

Accept 835(reported at EIN/TIN level): No

Maximum Clients:

Pediatric Services:

FQHC:

Language(s) Spoken: English Arabic Chinese (For Multiple Selection, use Ctrl Key)

OK Cancel

Page ID: dlgEntAddLocation(Provider)

- Complete Address Line 1 and Zip Code, click Validate Address
(Please Note: you should receive confirmation "Address Validation Successful")
- Complete all other fields marked with an asterisk (*)
- Click Ok



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Add

To add/modify Pay To, Correspondence and Remittance Advice addresses, click on Location Type hyperlink

Locations List

Filter By



Go

Save Filters

My Filters ▾

Doing Business As

Location Type

Location Details

End Date



Primary Practice Location

320 S Walnut St, Lansing, MICHIGAN 48933

12/31/2999



View Page:

1



Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- Click Primary Practice Location to add Pay-To address

(Please Note: Correspondence address is required for all locations. Enter Remittance Advise address only to receive a paper Remittance Advice)

Application ID: 20171115618358

Name: Tester, Test

 To add additional addresses, click "Add Address" button.

Location Details

Doing Business As:

Location Code: 1

Location Type: Primary Practice Location

Phone Number: * Extn: Fax Number: Email Address: Web Page: Communication

Preference:

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	<input type="text" value="Close"/> *	<input type="text" value="AM"/> *	<input type="text" value=""/> *	<input type="text" value="PM"/> *	Thursday:	<input type="text" value="07:00"/> *	<input type="text" value="AM"/> *	<input type="text" value="06:00"/> *	<input type="text" value="AM"/> *
Monday:	<input type="text" value="07:00"/> *	<input type="text" value="AM"/> *	<input type="text" value="06:00"/> *	<input type="text" value="PM"/> *	Friday:	<input type="text" value="07:00"/> *	<input type="text" value="AM"/> *	<input type="text" value="06:00"/> *	<input type="text" value="AM"/> *
Tuesday:	<input type="text" value="07:00"/> *	<input type="text" value="AM"/> *	<input type="text" value="06:00"/> *	<input type="text" value="PM"/> *	Saturday:	<input type="text" value="09:00"/> *	<input type="text" value="AM"/> *	<input type="text" value="03:00"/> *	<input type="text" value="AM"/> *
Wednesday:	<input type="text" value="07:00"/> *	<input type="text" value="AM"/> *	<input type="text" value="06:00"/> *	<input type="text" value="PM"/> *					

Accepting New Clients: Maximum Clients: Handicap Accessible: Offers OB-Gyn Services: Pediatric Services: FQHC: Accept 835 (reported at EIN/TIN level): Language(s) Spoken:
(For Multiple Selection, use Ctrl Key)End Date:

Address List

Address Type

☐

Location

Address

☐

End Date

☐

12/31/2999

View Page: 1

Viewing Page: 1

- Click Add Address

Application ID: 20171115618358

Name: Tester, Test

Add Provider Location Address

Type of Address: --SELECT-- ▾

End Date:

Location Address: ☐ Copy This Location Address

If a department or drawer number is required enter the information in line TWO.(For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

Address Line 1: *

(Enter Street Address or PO Box Only)

Address Line 3:

State/Province: OTHER ▾ *

Country: UNITED STATES ▾ *

Address Line 2:

City/Town: OTHER ▾ *

County: OTHER ▾

Zip Code: - 

OK



- From the drop-down list, select Type of Address
- Complete all fields marked with an asterisk (*)
- Click Validate Address

(Please Note: you should receive confirmation "Address Validation Successful")

- Click Ok

CHAMPS Provider

Individual Enrollment > General

Application ID: 20171115618358 Name: Tester, Test

To add additional addresses, click "Add Address" button.

Location Details

Doing Business As: Location Code: 1 Location Type: Primary Practice Location

Phone Number: * Extn: Fax Number: Email Address:

Web Page: Communication Preference:

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

Day	Open At	AM/PM	Close At	AM/PM	Day	Open At	AM/PM	Close At	AM/PM
Sunday:	Close	AM		AM	Thursday:	07:00	AM	06:00	AM
		PM		PM			PM		PM
Monday:	07:00	AM	06:00	AM	Friday:	07:00	AM	06:00	AM
		PM		PM			PM		PM
Tuesday:	07:00	AM	06:00	AM	Saturday:	09:00	AM	03:00	AM
		PM		PM			PM		PM
Wednesday:	07:00	AM	06:00	AM					
		PM		PM					

Accepting New Clients: Maximum Clients: Handicap Accessible:

Offers OB-Gyn Services: Pediatric Services: FQHC:

Accept 835(reported at EIN/TIN level): Language(s) Spoken:

End Date: 12/31/2999

Address List

Address Type	Address	End Date
<input type="checkbox"/> Correspondence		12/31/2999
<input type="checkbox"/> Location		12/31/2999
<input type="checkbox"/> Pay To		12/31/2999
<input type="checkbox"/> Remittance Advice		12/31/2999

View Page: 1 Viewing Page: 1

- When all address locations are complete, click Save
(Please Note: If the address is the same you can click on the radio button that says, Copy This Location Address; example on previous slide.)
- Click Close



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Add

To add/modify Pay To, Correspondence and Remittance Advice addresses, click on Location Type hyperlink

Locations List

Filter By



Go

Save Filters

My Filters ▾

Doing Business As

Location Type

Location Details

End Date



Primary Practice Location

320 S Walnut St, Lansing, MICHIGAN 48933

12/31/2999



Delete

View Page:

1



Go



Page Count



SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- Click Close

Application ID: 20171115618358

Name: Tester, Test

Close

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/15/2017	11/15/2017	Complete	
Step 2: Add Locations	Required	11/15/2017	11/15/2017	Complete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Associate Billing Provider	Optional			Incomplete	
Step 5: Add License/Certification/Other	Optional			Incomplete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Associate MCO Plan	Optional			Incomplete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page:

1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- Step 2 is complete
- Click on Step 3: Add Specialties



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Add

Primary Speciality



Specialty/Subspecialty List



Filter By



Go

Save Filters

My Filters ▾

Specialty/Subspecialty

△ ▾

Provider Type

△ ▾

End Date

△ ▾

No Records Found !

- Click Add

CHAMPS My Inbox Provider

https://milogintp.michigan.gov/ - Welcome to MMS - Internet Explorer

Print Help

Application ID: 20171115618358 Name: Tester, Test

Add Specialty/Subspecialty

Location: 01- *
Provider Type: ---SELECT--- *
Specialty: *
End Date:

Add Subspecialty

Available Subspecialties		Associated Subspecialties *
	» «	

OK Cancel

Page ID: dlgEnrlAddSpecialties(Provider)

- Choose appropriate Location, Provider Type, and Specialty
(Please Note: There is no need to fill in an End Date)
- Dependent on the Specialty chosen, Available Subspecialties will populate

CHAMPS

My Inbox ▾ Provider ▾

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20171115618358 Name: Tester, Test

Add Specialty/Subspecialty

Location: 01- ▾ *


Provider Type: PHYSICIANS ▾ *

Specialty: ---SELECT--- ▾ *

☒ Board Certified

☐ Board Eligible

☐ Not Board Certified / Eligible

End Date: 

Add Subspecialty

Available Subspecialties

Associated Subspecialties *

»

«

OK Cancel

Page ID: dlqEnrlAddSpecialties(Provider)

- Select the Specialty
- Dependent on the Specialty, select the appropriate board information

Application ID: 20171115618358

Name: Tester, Test

Add Specialty/Subspecialty

Location: 01- ▾ *

Provider Type: PHYSICIANS ▾ *

Specialty: General Practice ▾ *

End Date: 

Add Subspecialty

Available Subspecialties

Associated Subspecialties *



✓ OK

Cancel

- When Provider Type and Specialty have been chosen, the available subspecialties will be listed
- Select Available Subspecialties, click >> to add to Associated Subspecialties list
- When complete, click Ok



My Inbox ▾

Provider ▾



Note Pad

External Links ▾

★ My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

+ Add

Primary Speciality



Specialty/Subspecialty List



Filter By



Go

Save Filters

My Filters ▾

Specialty/Subspecialty

Provider Type

End Date



☐ General Practice/No Subspecialty

PHYSICIANS

12/31/2999



View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- Once all Specialties/Subspecialties have been added, click Primary Speciality



My Inbox ▾

Provider ▾



Note Pad

External Links ▾

★ My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Save



Primary Specialty For Enrollment



Primary Specialty/Subspecialty: PHYSICIANS/General Practice/No Subspecialty ▾ *

Board Certified: ☒ Yes ☐ No

Board Eligible: ☐ Yes ☒ No

Start Date: 01/01/2015 *

End Date: 12/31/2999

Your designation and attestation of a primary specialty will be utilized to identify and evaluate your eligibility for the Primary Care Rate Increase.

(If Board Certified, please provide Board Certification No. in License/Certification/Other step.)

(If Board Eligible, please provide Board Eligibility Information. in License/Certification/Other step.)

- Choose Primary Specialty/Subspecialty from the drop-down list of already added specialties
- Select Yes if Board Certified or Board Eligible
- Enter Start Date
- Click Save
- Click Close



My Inbox ▾

Provider ▾



Note Pad

External Links ▾

★ My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Add

Primary Speciality



Specialty/Subspecialty List



Filter By



Go

Save Filters

My Filters ▾

Specialty/Subspecialty

Provider Type

End Date



☐ General Practice/No Subspecialty

PHYSICIANS

12/31/2999



View Page: 1



Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- To return to the enrollment steps, click Close



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/15/2017	11/15/2017	Complete	
Step 2: Add Locations	Required	11/15/2017	11/15/2017	Complete	
Step 3: Add Specialties	Required	11/15/2017	11/15/2017	Complete	
Step 4: Associate Billing Provider	Optional			Incomplete	
Step 5: Add License/Certification/Other	Required			Incomplete	Please add required License/Certification.
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Associate MCO Plan	Optional			Incomplete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- Step 3 is complete
- Click on Step 4: Associate Billing Provider



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Add



Billing Provider List



Filter By



Go

Save Filters

My Filters ▾

Billing Provider NPI/ID

Billing Provider Name

Start Date

End Date

Status

△ ▾

△ ▾

△ ▾

△ ▾

△ ▾

No Records Found !

- Click Add

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20171115618358

Name: Tester, Test

Associate Billing Provider

Enter NPI/Provider ID of Billing Provider and click "Confirm Provider".

Type: NPI ▾ *

ID: *Start Date: 01/01/2017 *Provider Name: End Date:

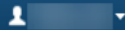
Page ID: dlgBillingProviderID(Provider)

- Complete all fields marked with an asterisk (*)
- Click Confirm Provider; Provider Name will populate
- Click Ok



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test



Close



Add



Billing Provider List



Filter By



Go

Save Filters

My Filters ▾

Billing Provider NPI/ID

Billing Provider Name

Start Date

End Date

Status



[Redacted]

[Redacted]

01/01/2017

12/31/2999

Approved

Delete

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- The associated providers information is now listed under the Billing Provider List
- Click Close



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/15/2017	11/15/2017	Complete	
Step 2: Add Locations	Required	11/15/2017	11/15/2017	Complete	
Step 3: Add Specialties	Required	11/15/2017	11/15/2017	Complete	
Step 4: Associate Billing Provider	Optional	11/15/2017	11/15/2017	Complete	
Step 5: Add License/Certification/Other	Required			Incomplete	Please add required License/Certification.
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Associate MCO Plan	Optional			Incomplete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- Step 4 is complete
- Click on Step 5: Add License/Certification/Other



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Add



License/Certification/Other List



Filter By



Go

Save Filters

My Filters ▾

License/Cert./Other Type

License/Cert./Other #

Location

Valid Flag

Effective Date

End Date



No Records Found !

- Click Add

CHAMPS

My Inbox ▾ Provider ▾

Quick Find Note Pad External Links ▾ My Favorites ▾ Print Help

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20171115618358 Name: Tester, Test

Add License/Certification/Other

Location: 01-320 s walnut ▾ *

License/Certification/Other Type: ▾ *

License/Certification/Other #: ▾ *

Valid Flag:

Effective Date: ▾ * End Date: ▾ *

☒ Confirm License/Certification/Other ☐ OK ☐ Cancel

Page ID: dlgEnrlmntAddLicense(Provider)

- Complete all fields marked with an asterisk (*)
- Click Confirm License/Certification/Other
- Click Ok



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test



License/Certification/Other List



Filter By



Save Filters

My Filters ▾

License/Cert./Other Type

License/Cert./Other #

Location

Valid Flag

Effective Date

End Date



☐ State Professional License



01-320 s walnut

No

01/01/2017

12/31/2999



View Page: 1



Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- The License/Certification/Other information will now be displayed
- To add additional License/Certification repeat the same process
- Click Close



Application ID: 20171115618358

Name: Tester, Test

Close

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/15/2017	11/15/2017	Complete	
Step 2: Add Locations	Required	11/15/2017	11/15/2017	Complete	
Step 3: Add Specialties	Required	11/15/2017	11/15/2017	Complete	
Step 4: Associate Billing Provider	Optional	11/15/2017	11/15/2017	Complete	
Step 5: Add License/Certification/Other	Required	11/15/2017	11/15/2017	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Associate MCO Plan	Optional			Incomplete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Go Page Count SaveToXLS

Viewing Page: 1

First Prev Next Last

- Step 5 is complete
- Click on Step 6: Add Mode of Claim Submission/EDI Exchange

Application ID: 20171115618358

Name: Tester, Test

Mode of Claims Submission/EDI exchange

Please select the submission methods from EDI Exchange and/or Other Claims Submission as applicable.

EDI exchange

Method	Description	Applicable Transactions
<input type="checkbox"/> Electronic Batch	To upload/download HIPAA transactions from screens (Maximum file upload size is 50MB)	837P- Professional (FFS), 837I -Institutional(FFS), 837D -Dental(FFS), 270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response
<input type="checkbox"/> CORE Batch	To upload/download HIPAA transactions using CORE Batch Connectivity	270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response, 835 Health Care Claim Payment/Advice
<input type="checkbox"/> CORE Real Time	To upload/download HIPAA transactions using CORE Real Time Connectivity	270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response
<input type="checkbox"/> Billing Agent	To submit/receive HIPAA transactions through billing agent	837P- Professional (FFS/Encounter), 837I -Institutional(FFS/Encounter), 837D -Dental(FFS/Encounter), 270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response, 278/278- Prior Authorization Request/Response, 835- Healthcare Claim payment Advice

Other Claims Submission

Method	Description
<input type="checkbox"/> Paper Claims	To submit FFS paper claims
<input type="checkbox"/> Direct Data Entry(DDE)	To submit FFS claims via online screens

✓ Ok

Cancel

- Under EDI exchange select appropriate claim submission method(s)
- Under Other Claims Submission select appropriate claim submission method(s)
- Click Ok



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/15/2017	11/15/2017	Complete	
Step 2: Add Locations	Required	11/15/2017	11/15/2017	Complete	
Step 3: Add Specialties	Required	11/15/2017	11/15/2017	Complete	
Step 4: Associate Billing Provider	Optional	11/15/2017	11/15/2017	Complete	
Step 5: Add License/Certification/Other	Required	11/15/2017	11/15/2017	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	11/15/2017	11/15/2017	Complete	
Step 7: Associate Billing Agent	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Associate MCO Plan	Optional			Incomplete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- Step 6 is complete
- Click on Step 7: Associate Billing Agent



Application ID: 20171115618358

Name: Tester, Test

Close Add



Billing Agent List



Filter By



Go

Save Filters

My Filters ▾

Billing Agent ID

Billing Agent Name

835 Authorization

Start Date

End Date



No Records Found !

- Click Add

Application ID: 20171115618358

Name: Tester, Test

Associate Billing Agent

Click on the 'Confirm/Search Billing Agent' button to search for a Billing Agent or confirm the Billing Agent entered.

Billing Agent ID: *

Billing Agent Name:

Association Start Date: *Association End Date:

Authorized Transaction Responses

Transaction Response	Authorized	Start Date	End Date
X12 835 - Healthcare Claim Status	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Confirm/Search Billing Agent

OK

Cancel

- To locate Billing Agent information, click Confirm/Search Billing Agent

CHAMPS

My Inbox ▾ Provider ▾

Quick Find Note Pad External Links ▾ My Favorites ▾ Print Help

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

https://milogintp.michigan.gov/ - Search Billing Agent List - Internet Explorer

Print Help

Application ID: 20171115618358 Name: Tester, Test

Billing Agent List

Filter By ▾ Go Save Filters My Filters ▾

Billing Agent ID	Billing Agent Name	Start Date	End Date
<input type="checkbox"/>		01/01/1984	12/31/2999
<input type="checkbox"/>		01/01/1984	12/31/2999
<input type="checkbox"/>		04/30/1998	12/31/2999
<input type="checkbox"/>		12/08/1999	12/31/2999
<input type="checkbox"/>		02/25/2000	12/31/2999
<input type="checkbox"/>		06/04/1999	12/31/2999
<input type="checkbox"/>		02/19/2002	12/31/2999

Select Close

Page ID: pgBillingAgentSearchList(Provider)

Page ID: dlgEnrlmntAssocSubmitter(Provider)

- Check the box next to the Billing Agent you want to select
(Please Note: There is more than one page of Billing Agents; you may select more than one)
- Click Select

Application ID: 20171115618358

Name: Tester, Test

Associate Billing Agent

Click on the 'Confirm/Search Billing Agent' button to search for a Billing Agent or confirm the Billing Agent entered.

Billing Agent ID: *Billing Agent Name: Association Start Date: 11/15/2017 *Association End Date: 12/31/2999

Authorized Transaction Responses

Transaction Response	Authorized	Start Date	End Date
X12 835 - Healthcare Claim Status	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Confirm/Search Billing Agent

✓ OK

Cancel

- Billing Agent information will populate
- Click Ok



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Add



Billing Agent List



Filter By



Go

Save Filters

My Filters ▾

Billing Agent ID	Billing Agent Name	835 Authorization	Start Date	End Date
<input type="checkbox"/> ▲▼	<input type="checkbox"/> ▲▼	<input type="checkbox"/> ▲▼	<input type="checkbox"/> ▲▼	<input type="checkbox"/> ▲▼
<input type="checkbox"/>		No	11/15/2017	12/31/2999

Delete

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- Billing Agent information has been added
- Click Close



Provider ▾



Last Login: 04 DEC, 2018 11:42 AM

Note Pad

External Links ▾

★ My Favorites ▾

Print

Help

New Enrollment > Individual Enrollment

Application ID: 20181204171383

Name: Test, Testing

Close

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	12/04/2018	12/04/2018	Complete	
Step 2: Add Locations	Required	12/04/2018	12/04/2018	Complete	
Step 3: Add Specialties	Required	12/04/2018	12/04/2018	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional			Complete	
Step 5: Add License/Certification/Other	Required	12/04/2018	12/04/2018	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	12/04/2018	12/04/2018	Complete	
Step 7: Associate Billing Agent	Required	12/04/2018	12/04/2018	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Associate MCO Plan	Optional			Incomplete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

<< First

< Prev

Next >

>> Last

- Step 7 is complete
- Click on Step 8: Add Provider Controlling Interest/Ownership Details
 - *The screens for this step were updated 12/14/18

CHAMPS Provider ▾

Last Login: 04 DEC, 2018 11:42 AM

Note Pad External Links ▾ My Favorites ▾ Print Help

New Enrollment > Individual Enrollment > General

Application ID: 20181204171383 Name: Test, Testing

Close + Actions ▾ ⓘ

- Manage Add Owner
- There Import Owner
- At least Owners Relationships

Owners Adverse Action

Corporate - Publicly Traded Holding Company Indirect Owner

Owners List

Filter By ▾ And Go Save Filters My Filters ▾

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
▾ ▴	▾ ▴	▾ ▴	▾ ▴	▾ ▴	▾ ▴	▾ ▴	▾ ▴	▾ ▴
	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Completed	Not Completed	100

Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 << First < Prev > Next >> Last

Add Other Owned Entity List Ownership Interest in other Entities reimbursible by Medicaid and/or Medicare.

Filter By ▾ Go Save Filters My Filters ▾

Other Owner EIN/TIN	Other Owner Information	Address
▾ ▴	▾ ▴	▾ ▴

No Records Found !

- To enter additional owner information, select Add Owner from the Actions drop-down menu
 - Note: The individual provider information prepopulates as a listed owner and the relationship status also prepopulates to completed.

CHAMPS Provider

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20181204171383 Name: Test, Testing

Provider Controlling Interest/Ownership

Type: *

Percentage Owned: *

SSN:

EIN/TIN:

Legal Entity Name:
(As shown on the Income Tax Return)

Entity Business Name:
(Doing Business As)

Owner NPI:

First Name:

Last Name:

Suffix:

DOB:

Phone Number: * **Extn:**

Email:

Start Date: *

End Date:

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County: *

Country: *

Zip Code: * -

Validate Address

Page ID: dlgEnrImntAddOwner(Provider)

- Select an Owner Type from the drop-down menu
- Complete all fields marked with an asterisk (*)
- Complete Address Line 1 and Zip Code, click Validate Address
(Please Note: you should receive confirmation "Address Validation Successful")
- Click Ok

CHAMPS Provider

Last Login: 04 DEC, 2018 11:42 AM

Note Pad External Links My Favorites Print Help

New Enrollment Individual Enrollment General

Application ID: 20181204171383 Name: Test, Testing

Close Actions

Per Medicaid Provider Manual

PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

Provider Enrollment Information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501(c)3	Corporate - Not Publicly Traded	Foreign, Nonresident Alien
Corporate - Non Charitable	Sub-contractor	Limited liability Company
Corporate - Publicly Traded	Holding Company	Indirect Owner

Owners List

Filter By And Go Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
123456789	Example,One	Managing Employee	100 N Capital Ave	01/01/2015	12/31/2999	Not Completed	Not Completed	0
	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Not Completed	Not Completed	100

Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

Add Other Owned Entity List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By And Go Save Filters My Filters

Other Owner EIN/TIN	Other Owner Information	Address

No Records Found !

- The managing employee is now added to the list of owners
- To add the relationship click the Actions drop-down menu
 - Note: The Relationship status for the individual provider enrolling is now marked as Not Completed

Application ID: 20181204171383

Name: Test, Testing

Close

Actions ▾



- There Add Owner ownership type in addition to Managing Employee. Corporate - Charitable 501[c]3
- At least Import Owner icers/Principal is required if one of the ownership types below is selected:
 - Owners Relationships 501[c]3 Corporate - Not Publicly Traded Foreign, Nonresident Alien
 - Owners Adverse Action Sub-contractor Limited liability Company
 - Holding Company Indirect Owner

Owners List

Filter By

And

Go

Save Filters

My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<div>▼</div>	<div>▼</div>	<div>▼</div>	<div>▼</div>	<div>▼</div>	<div>▼</div>	<div>▼</div>	<div>▼</div>	<div>▼</div>
123456789	Example,One	Managing Employee	100 N Capitol Ave	01/01/2015	12/31/2999	Not Completed	Not Completed	0
	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Not Completed	Not Completed	100

Delete

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

Add Other Owned Entity List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By

Go

Save Filters

My Filters

Other Owner EIN/TIN	Other Owner Information	Address
<div></div>		
No Records Found !		

- Select Owners Relationships from the Actions drop-down menu

CHAMPS Provider

Last Login: 04 DEC, 2018 11:42 AM

https://milogintpc.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20181204171383 Name: Test, Testing

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☐ Yes ☐ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

Selected Owner: Test, Testing SSN/EIN/TIN: Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Test, Testing	Relation to Assoc. Owner
Example, One	123456789	Managing Employee		
Test, Testing		Individual		None

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

Selected Owner: Example, One SSN/EIN/TIN: 123456789 Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- Answer question (at the top)
- If no relationships exist select No.
 - If the owners have a relationship to one another, refer to the [Step 8: Add Provider Controlling Interest/Ownership Details](#) user guide.

CHAMPS Provider

Last Login: 04 DEC, 2018 11:42 AM

https://milointpc.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20181204171383 Name: Test, Testing

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☐ Yes ☒ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

Selected Owner: Test, Testing	SSN/EIN/TIN:	Status: Not Completed
Selected Owner: Example, One	SSN/EIN/TIN: 123456789	Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- The owner list boxes collapse
- Click Save

CHAMPS Provider

Last Login: 04 DEC, 2018 11:42 AM

https://milogintps.michigan.gov/ - Welcome to MMIS - Internet Explorer

Application ID: 20181204171383 Name: Test, Testing

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☐ Yes ☒ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

Selected Owner: Test, Testing	SSN/EIN/TIN	Status: Not Completed
Selected Owner: Example, One	SSN/EIN/TIN: 123456789	

Message from webpage

? All owner relationships will be set to 'None'. Do you want to continue?

OK Cancel

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- After clicking save, click Ok.

CHAMPS

Provider

Last Login: 04 DEC, 2018 11:42 AM

https://milogintpi.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20181204171383 Name: Test, Testing

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☐ Yes ☐ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

> Selected Owner: Test, Testing	SSN/EIN/TIN: [REDACTED]	Status: Completed
> Selected Owner: Example, One	SSN/EIN/TIN: 123456789	Status: Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- The status for each owner will show Completed
- Click close to return to the owner list screen

Provider

Last Login: 04 DEC, 2018 11:42 AM

Note Pad

External Links

My Favorites

Print

Help

New Enrollment

Individual Enrollment

General

Application ID: 20181204171383

Name: Test, Testing

Close

Actions

Per Medicaid Provider Manual

PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

Provider Enrollment Information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501(c)3	Corporate - Not Publicly Traded	Foreign, Nonresident Alien
Corporate - Non Charitable	Sub-contractor	Limited liability Company
Corporate - Publicly Traded	Holding Company	Indirect Owner

Owners List

Filter By

And

Go

Save Filters

My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 123456789	Example,One	Managing Employee	100 N Capitol Ave	01/01/2015	12/31/2999	Completed	Not Completed	0
<input type="checkbox"/>	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Completed	Not Completed	100

Delete

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

Add Other Owned Entity

List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By

Go

Save Filters

My Filters

Other Owner EIN/TIN	Other Owner Information	Address
<input type="checkbox"/>		

No Records Found !

- The Relationship Status now shows Completed for both owners

Michigan Department of Health & Human Services



Provider

Last Login: 04 DEC, 2018 11:42 AM

Note Pad

External Links

My Favorites

Print

Help

New Enrollment > Individual Enrollment > General

Application ID: 20181204171383

Name: Test, Testing

Close

Actions



- There Add Owner ownership type in addition to Managing Employee. Corporate - Charitable 501[c]3
- At least Import Owner icers/Principal is required if one of the ownership types below is selected:
 - Owners Relationships 501[c]3 Corporate - Not Publicly Traded Foreign, Nonresident Alien
 - Sub-contractor Limited liability Company
 - Owners Adverse Action Holding Company Indirect Owner

Owners List

Filter By And Go

Save Filters

My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> 123456789	Example,One	Managing Employee	100 N Capitol Ave	01/01/2015	12/31/2999	Completed	Not Completed	0
<input type="checkbox"/> !	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Completed	Not Completed	100

Delete View Page: 1 Go Page Count SaveToXLS

Viewing Page: 1

First Prev Next Last

Add Other Owned Entity List Ownership Interest in other Entities reimbursible by Medicaid and/or Medicare.

Filter By Go

Save Filters

My Filters

Other Owner EIN/TIN	Other Owner Information	Address
<input type="checkbox"/> ▲▼	▲▼	▲▼
No Records Found !		

- Select Owners Adverse Action from the Actions drop-down menu to complete the Final Adverse Legal/Action/Convictions Disclosure

CHAMPS Provider

https://milogintp.michigan.gov/ - Owners with Adverse Action - Internet Explorer

Print Help

Application ID: 20181204171383 Name: Test, Testing

FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries or recipients. Offenses include, but are not limited to: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any misdemeanor or felonies that may result in a mandatory or permissive exclusion under State or Federal law.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicaid or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicaid payment suspension under any Medicaid enrollment.
5. Any Medicaid revocation of any Medicaid provider billing number.

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

Do any of the owners, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against them? Please answer in the 'Owners with Adverse Action' section below for each owner.

Owners with Adverse Action

Owner Name	Response	Comments
Test, Testing	<input type="radio"/> Yes <input type="radio"/> No	
Example, One	<input type="radio"/> Yes <input type="radio"/> No	

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1

First Prev Next Last

Ok Cancel

Page ID: pgEnrlmntAdverseAction(Provider)

- Read through Final Adverse Legal Actions/Convictions statement for each owner listed, select Yes or No

Application ID: 20181204171383

Name: Test, Testing

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicaid payment suspension under any Medicaid enrollment.
5. Any Medicaid revocation of any Medicaid provider billing number.

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

Do any of the owners, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against them? Please answer in the 'Owners with Adverse Action' section below for each owner.

Owners with Adverse Action

Owner Name ▲▼	Response ▲▼	Comments ▲▼
Test, Testing	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>
Example, One	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>

View Page: 1



Go

Page Count

SaveToXLS

Viewing Page: 1

<< First

< Prev

> Next

>> Last

☒ Ok☐ Cancel

- Click Ok

CHAMPS Provider

Last Login: 04 DEC, 2018 11:42 AM

Note Pad External Links My Favorites Print Help

New Enrollment Individual Enrollment General

Application ID: 20181204171383 Name: Test, Testing

Close Actions

Per Medicaid Provider Manual

PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

Provider Enrollment Information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501[c]3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

Corporate - Charitable 501[c]3	Corporate - Not Publicly Traded	Foreign, Nonresident Alien
Corporate - Non Charitable	Sub-contractor	Limited liability Company
Corporate - Publicly Traded	Holding Company	Indirect Owner

Owners List

Filter By And Go Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> 123456789	Example,One	Managing Employee	100 N Capitol Ave	01/01/2015	12/31/2999	Completed	No	0
<input type="checkbox"/>	Test,Testing	Individual	320 S Walnut St	12/04/2018	12/31/2999	Completed	No	100

Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1

List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Add Other Owned Entity

Filter By Go Save Filters My Filters

Other Owner EIN/TIN	Other Owner Information	Address
<input type="checkbox"/>		

No Records Found !

- The Adverse Action column will show Yes or No indicating it's complete.
- Click Close



Provider



Last Login: 04 DEC, 2018 11:42 AM

Note Pad

External Links

My Favorites

Print

Help

New Enrollment > Individual Enrollment

Application ID: 20181204171383

Name: Test, Testing

Close

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	12/04/2018	12/04/2018	Complete	
Step 2: Add Locations	Required	12/04/2018	12/04/2018	Complete	
Step 3: Add Specialties	Required	12/04/2018	12/04/2018	Complete	
Step 4: Associate Billing Provider/Other Associations	Optional			Complete	
Step 5: Add License/Certification/Other	Required	12/04/2018	12/04/2018	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	12/04/2018	12/04/2018	Complete	
Step 7: Associate Billing Agent	Required	12/04/2018	12/04/2018	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	12/04/2018	12/04/2018	Complete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Associate MCO Plan	Optional			Incomplete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page:

1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- Step 8 is complete
- Click on Step 9: Add Taxonomy Details



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Add



Taxonomy List



Filter By



Go

Save Filters

My Filters ▾

Taxonomy Code

Description

Start Date

End Date



No Records Found !

- Click Add

CHAMPS

My Inbox ▾ Provider ▾

https://milogintpmichigan.gov/ - Welcome to MMIS - Internet Explorer



Print Help

Application ID: 20171115618358 Name: Tester, Test

Add Taxonomy


Taxonomy Code: (Click here for Taxonomy List) Location: 01-320 s walnut ▾ *

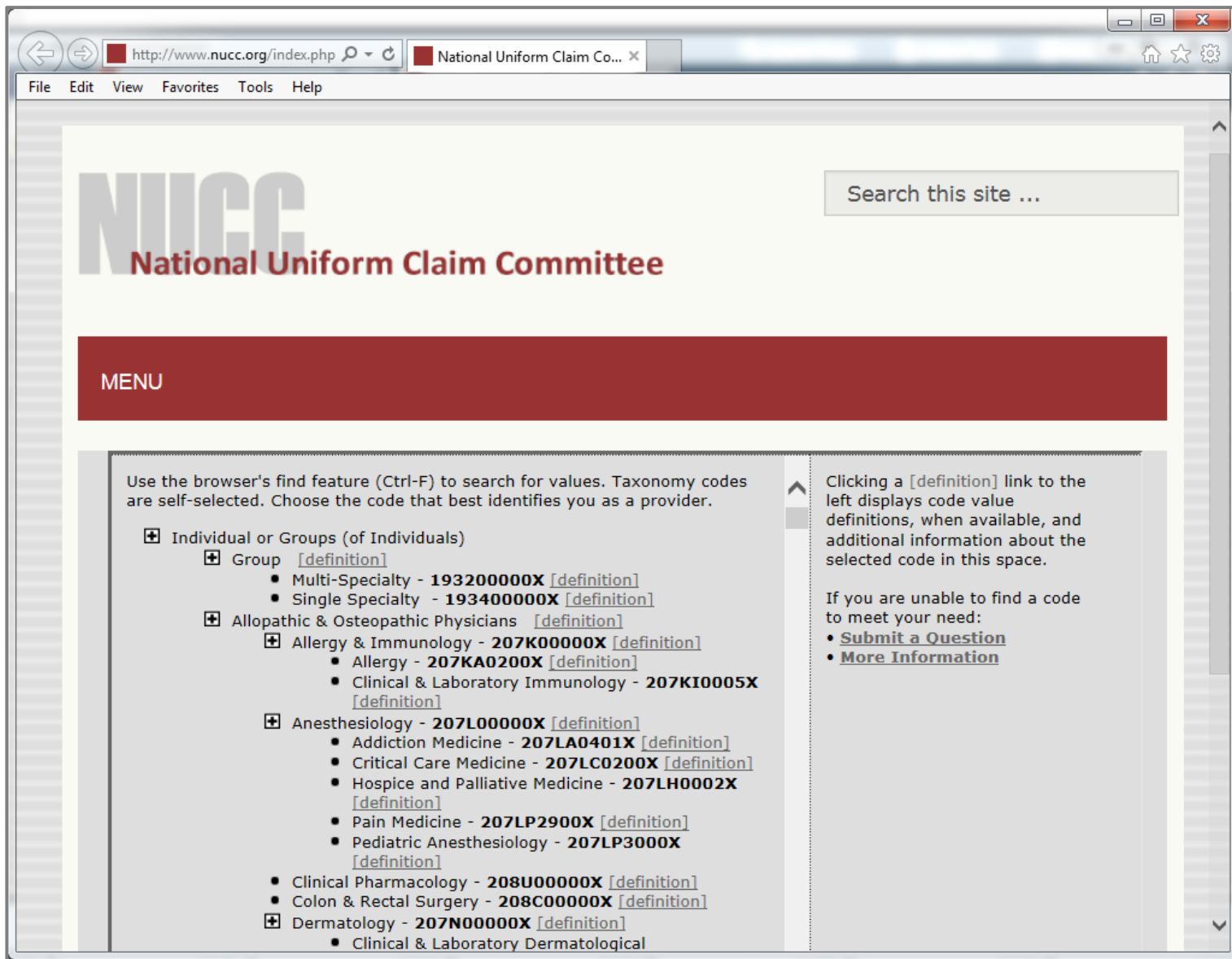
Description:

Start Date:  * End Date: 

Confirm Taxonomy Ok Cancel

Page ID: dlgEnrAddTaxonomy(Provider)

- Enter in Taxonomy Code or click on () next to the words, Click here for Taxonomy List, to look up appropriate taxonomy code



- After clicking (🔍) the [National Uniform Claim Committee](http://www.nucc.org/index.php) webpage will pop-up
- Press (CTRL+F) to search for appropriate taxonomy code

Application ID: 20171115618358

Name: Tester, Test

Add Taxonomy

Taxonomy Code: * (Click here for Taxonomy List)

Location: 01-320 s walnut ▾ *

Description:

Start Date: *End Date:

Page ID: dlgEnrAddTaxonomy(Provider)

- Enter Start Date *(Please Note: Must be current date or date of application)*
- Click Confirm Taxonomy
- Click Ok



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Add



Taxonomy List



Filter By



Go

Save Filters

My Filters ▾

Taxonomy Code	Description	Start Date	End Date
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/> 207V00000X	Obstetrics & Gynecology	11/15/2017	12/31/2999

Delete

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- The Taxonomy Code information will be displayed
- Click Close



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close



Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/15/2017	11/15/2017	Complete	
Step 2: Add Locations	Required	11/15/2017	11/15/2017	Complete	
Step 3: Add Specialties	Required	11/15/2017	11/15/2017	Complete	
Step 4: Associate Billing Provider	Optional	11/15/2017	11/15/2017	Complete	
Step 5: Add License/Certification/Other	Required	11/15/2017	11/15/2017	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	11/15/2017	11/15/2017	Complete	
Step 7: Associate Billing Agent	Optional	11/15/2017	11/15/2017	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	11/15/2017	11/15/2017	Complete	
Step 9: Add Taxonomy Details	Required	11/15/2017	11/15/2017	Complete	
Step 10: Associate MCO Plan	Optional			Incomplete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

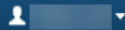
Last

- Step 9 is complete
- Click on Step 10: Associate MCO Plan (Please Note: This step is optional)



My Inbox ▾

Provider ▾



Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID:20171115618358

Name: Tester, Test

Close

Add



MCO Plan List



Filter By



Go

Save Filters

My Filters ▾

Plan ID	Plan Name	Business Status	Business Status Start Date	Business Status End Date	Association Start Date	Association End Date	Program Description
▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼

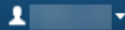
No Records Found !

- Step is optional, if you do not work for a Managed Care Organization (MCO) plan, click Close



My Inbox ▾

Provider ▾



Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID:20171115618358

Name: Tester, Test

Close

Add



MCO Plan List



Filter By



Go

Save Filters

My Filters ▾

Plan ID	Plan Name	Business Status	Business Status Start Date	Business Status End Date	Association Start Date	Association End Date	Program Description
▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼

No Records Found !

- If choosing to add an MCO Plan List;
- Click Add to associate an MCO plan

Application ID: 20171115618358

Name: Tester, Test

Associate MCO Plan

Click on the 'Confirm/Search Plan' button to search for a MCO Plan or confirm the Plan ID entered

Please associate only to plans with which you have a signed contract

Plan ID: *

Plan Name:

Program Name:

Program Description:

Association Start Date: *Association End Date:

Confirm/Search Plan

Ok

Cancel

Page ID: dlgEnrlmntAssocMCOPlanID(Provider)

- To locate the MCO Plan , click Confirm/Search Plan

CHAMPS My Inbox Provider

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

https://milogintp.michigan.gov/ - MCO Plan Search List - Internet Explorer

Print Help

Application ID: 20171115618358 Name: Tester, Test

MCO Plan Search List

Filter By [v] [] Go Save Filters My Filters

Plan ID	Plan Name	Business Status	Business Status Start Date	Business Status End Date	Program Name	Program Type
<input checked="" type="checkbox"/>		Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	12/04/2014	12/31/2999	ICO-MC	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	12/21/1993	12/31/2999	MHP	Managed Care Comprehensive Medical Program Type
<input type="checkbox"/>		Active	04/04/2005	12/31/2999	MHP	Managed Care Comprehensive Medical Program Type

Page ID: pgMCOPlanSearchList(Provider)

Confirm/Search Plan OK Cancel

Page ID: dlgEnrlmntAssocMCOPlanID(Provider)

Select Close

- Check the box next to the MCO Plan you want to select
(Please Note: There is more than one page of MCO plans; you may select more than one)
- Click Select

Application ID: 20171115618358

Name: Tester, Test

Associate MCO Plan

Click on the 'Confirm/Search Plan' button to search for a MCO Plan or confirm the Plan ID entered

Please associate only to plans with which you have a signed contract

Plan ID: *Plan Name:

Program Name: MHP

Program Description: ManagedCareProgram

Association Start Date: 11/20/2017 *Association End Date: 12/31/2999

Page ID: dlgEnrImntAssocMCOPlanID(Provider)

- MCO Plan information will populate
- Click Ok



My Inbox ▾

Provider ▾



Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Add



MCO Plan List



Filter By



Go

Save Filters

My Filters ▾

<input type="checkbox"/>	Plan ID ▲▼	Plan Name ▲▼	Business Status ▲▼	Business Status Start Date ▲▼	Business Status End Date ▲▼	Association Start Date ▲▼	Association End Date ▲▼	Program Description ▲▼
<input type="checkbox"/>			Active	12/21/1993	12/31/2999	11/15/2017	12/31/2999	ManagedCareProgram

Delete

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- MCO Plan information has been associated
- Click Close



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close



Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/15/2017	11/15/2017	Complete	
Step 2: Add Locations	Required	11/15/2017	11/15/2017	Complete	
Step 3: Add Specialties	Required	11/15/2017	11/15/2017	Complete	
Step 4: Associate Billing Provider	Optional	11/15/2017	11/15/2017	Complete	
Step 5: Add License/Certification/Other	Required	11/15/2017	11/15/2017	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	11/15/2017	11/15/2017	Complete	
Step 7: Associate Billing Agent	Optional	11/15/2017	11/15/2017	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	11/15/2017	11/15/2017	Complete	
Step 9: Add Taxonomy Details	Required	11/15/2017	11/15/2017	Complete	
Step 10: Associate MCO Plan	Optional	11/15/2017	11/15/2017	Complete	
Step 11: 835/ERA Enrollment Form	Optional			Incomplete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page:

1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- Step 10 is complete
- Click on Step 11: 835/ERA Enrollment Form (Please Note: This step is optional)

CHAMPS < My Inbox > Provider >

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358 Name: Tester, Test

Close Submit Print Help

ERA ENROLLMENT FORM

PROVIDER INFORMATION

Provider Name: Tester,Test

Doing Business As Name (DBA):

Provider Address

Street: 320 S Walnut St State/Province: MICHIGAN

City: Lansing Zip Code/Postal Code: 48933

Country Code: UNITED STATES

PROVIDER IDENTIFIERS

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):

National Provider Identifier (NPI):

Other Identifier(s)

Assigning Authority: Trading Partner ID:

Provider License Details

Provider License No: License Issuer: MI

Provider Type: PHYSICIANS

PROVIDER CONTACT INFORMATION

Provider Contact Name

Contact: Test_One Title: Managing Employee

Telephone Number: Telephone Number Extension:

Email Address: Fax Number:

PROVIDER AGENT INFORMATION

Provider Agent Name:

Agent Address

Street: State/Province:

City: Zip Code/Postal Code:

Country Code:

Provider Agent Contact Name

Provider Agent Contact Name: Title:

Telephone Number: Telephone Number Extension:

Email Address: Fax Number:

- Step is optional, fill out if provider would like to directly receive their 835 (i.e., electronic remittance advice (ERA))
(Please Note: within step 2 providers would have needed to select Yes, to question “Accept 835?”)
- Complete all fields marked with an asterisk (*)

<div> <div></div> <div>FEDERAL AGENCY INFORMATION (Not applicable at this time)</div> </div>	
Federal Program Agency Name: <input type="text"/> Federal Agency Location Code: <input type="text"/>	Federal Program Agency Identifier: <input type="text"/>
<div> <div></div> <div>RETAIL PHARMACY INFORMATION(Not applicable at this time)</div> </div>	
Pharmacy Name	
Pharmacy Name: <input type="text"/> Parent: <input type="text"/> Payment Center ID: <input type="text"/> NCPDP Provider ID Number: <input type="text"/> Medicaid Provider Number: <input type="text"/>	Chain Number: <input type="text"/> Organization ID: <input type="text"/>
<div> <div></div> <div>ELECTRONIC REMITTANCE ADVICE INFORMATION</div> </div>	
Preference for Aggregation of Remittance Data(e.g., Account Number Linkage to Provider Identifier) <input type="radio"/> NPI <input checked="" type="radio"/> TAX ID * MI Medicaid enumerates by Tax ID only. Method of Retrieval: <input type="text"/> *	
<div> <div></div> <div>ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION (Not applicable at this time)</div> </div>	
ClearingHouse Name: <input type="text"/> ClearingHouse Contact Name ClearingHouse Contact Name: <input type="text"/> Email Address: <input type="text"/> Telephone Number: <input type="text"/>	
<div> <div></div> <div>ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION (Not applicable at this time)</div> </div>	
Vendor Name: <input type="text"/> Vendor Contact Vendor Contact Name: <input type="text"/> Email Address: <input type="text"/> Telephone Number: <input type="text"/>	
<div> <div></div> <div>SUBMISSION INFORMATION</div> </div>	
Reason for Submission <input type="radio"/> Cancel Enrollment <input type="radio"/> Change Enrollment <input checked="" type="radio"/> New Enrollment * Authorized Signature Electronic Signature of Person Submitting Enrollment: <input type="checkbox"/> Authorization Agreement-By selecting the checkbox above, I hereby agree that I have read and agree to the terms and conditions stated in the Authorization Agreement below. Authorization Agreement By signing this request, I am authorizing the Michigan Department Of Health and Human Services to establish an 835/ERA account for the Tax ID listed above and for 835/ERA files to be transmitted electronically to the designated entity. Written Signature of Person Submitting Enrollment: <input type="text"/> Printed Name of Person Submitting Enrollment: <input type="text"/> Printed Title of Person Submitting Enrollment: <input type="text"/> Submission Date: 11/15/2017 Requested ERA Effective Date: (Once approve the next paycycle date.)	

- Complete all fields marked with an asterisk (*)

Application ID: 20171115618358

Name: Tester, Test



Close



Submit



Print



Help



ERA ENROLLMENT FORM



PROVIDER INFORMATION



Provider Name: Tester, Test

Doing Business As Name (DBA):

Provider Address

Street: 320 S Walnut St

State/Province: MICHIGAN

City: Lansing

Zip Code/Postal Code: 48933

Country Code: UNITED STATES



PROVIDER IDENTIFIERS



Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):

National Provider Identifier (NPI):

Other Identifier(s)

Assigning Authority:

Trading Partner ID:

Provider License Details

Provider License No:

License Issuer: MI

Provider Type: PHYSICIANS



PROVIDER CONTACT INFORMATION



Provider Contact Name

Contact: Test,One

Title: Managing Employee

Telephone Number:

Telephone Number Extension:

Email Address:

Fax Number:

- Click Submit
- Click Close



Application ID: 20171115618358

Name: Tester, Test

Close

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/15/2017	11/15/2017	Complete	
Step 2: Add Locations	Required	11/15/2017	11/15/2017	Complete	
Step 3: Add Specialties	Required	11/15/2017	11/15/2017	Complete	
Step 4: Associate Billing Provider	Optional	11/15/2017	11/15/2017	Complete	
Step 5: Add License/Certification/Other	Required	11/15/2017	11/15/2017	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	11/15/2017	11/15/2017	Complete	
Step 7: Associate Billing Agent	Optional	11/15/2017	11/15/2017	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	11/15/2017	11/15/2017	Complete	
Step 9: Add Taxonomy Details	Required	11/15/2017	11/15/2017	Complete	
Step 10: Associate MCO Plan	Optional	11/15/2017	11/15/2017	Complete	
Step 11: 835/ERA Enrollment Form	Optional	11/15/2017	11/15/2017	Complete	
Step 12: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1



Page Count



Viewing Page: 1



- Step 11 is complete
- Click on Step 12: Upload Documents (Please Note: This step is optional)



My Inbox ▾

Provider ▾



Note Pad

External Links ▾

★ My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test



Close



Document List



Add

Filter By ▾



Go

Save Filters

My Filters ▾

Document ID	Document Type	Document Name	File Name	Start Date	End Date	Uploaded By	Uploaded Date	Status
<input type="checkbox"/> ▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼

No Records Found !

- This step is optional, if documentation needs to be uploaded, click Add
- If not, click Close

CHAMPS My Inbox Provider

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20171115618358 Name: Tester, Test

Upload Document

Document Type: **SELECT** *
Certification
Contract
General
License

Associated MCO ID:

Document Name: *
Program Name:

File Name: Browse...

Start Date:

End Date:

Remark:

OK Cancel

Page ID: dlgEnrlmntAttachment(Provider)

- If provider chooses to upload a document;
- Select the document type and document name
- Click Browse to find the saved document on your computer
- Enter any other additional information
- Click Ok

Application ID: 20171115618358

Name: Tester, Test

Close

Document List

Add

Filter By ▾ Go

Save Filters My Filters ▾

Document ID ▲▼	Document Type ▲▼	Document Name ▲▼	File Name ▲▼	Start Date ▲▼	End Date ▲▼	Uploaded By ▲▼	Uploaded Date ▲▼	Status ▲▼
<input type="checkbox"/>	Certification	Board Certification					11/15/2017	In Process

Delete View Page: 1 Go Page Count SaveToXLS

Viewing Page: 1

First Prev Next Last

- The documentation has been added
- To return to the enrollment steps, click Close



My Inbox ▾

Provider ▾



Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close



Enroll Provider - Individual



Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/15/2017	11/15/2017	Complete	
Step 2: Add Locations	Required	11/15/2017	11/15/2017	Complete	
Step 3: Add Specialties	Required	11/15/2017	11/15/2017	Complete	
Step 4: Associate Billing Provider	Optional	11/15/2017	11/15/2017	Complete	
Step 5: Add License/Certification/Other	Required	11/15/2017	11/15/2017	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	11/15/2017	11/15/2017	Complete	
Step 7: Associate Billing Agent	Optional	11/15/2017	11/15/2017	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	11/15/2017	11/15/2017	Complete	
Step 9: Add Taxonomy Details	Required	11/15/2017	11/15/2017	Complete	
Step 10: Associate MCO Plan	Optional	11/15/2017	11/15/2017	Complete	
Step 11: 835/ERA Enrollment Form	Optional	11/15/2017	11/15/2017	Complete	
Step 12: Upload Documents	Optional	11/15/2017	11/15/2017	Complete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page:

1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- Step 12 is complete
- Click on Step 13: Complete Enrollment Checklist

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close Save

Provider Checklist

Question	Answer	Comments
Do you need to request a Retro Enrollment Date? If Yes, enter the requested Retro Enrollment Date in the comment field.	Not Completed ▾	
Are you currently excluded from any State program?	Not Completed ▾	
Are you currently excluded from any Federal program?	Not Completed ▾	
Have you ever had a criminal or health-related conviction?	Not Completed ▾	
Have you ever had a judgment under any false claims act?	Not Completed ▾	
Have you ever had a program exclusion/debarment?	Not Completed ▾	
Have you ever had a civil monetary penalty?	Not Completed ▾	
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	Not Completed ▾	
Do you have ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	Not Completed ▾	
Do you accept new patients?	Not Completed ▾	
Have you had any malpractice settlement, judgment, or agreement? If yes, enter dollar amount(s) and date(s).	Not Completed ▾	
If you are a Nurse Practitioner or Nurse Midwife, a Collaborative Agreement is required. Please provide NPI of servicing physician. If you don't have an agreement, please answer yes and provide an explanation.	Not Completed ▾	
Dental Hygienist-Do you have a collaborative agreement in place? If 'Yes', with what NPI?	Not Completed ▾	
Are you affiliated with a PA 161 program? If yes, please provide the NPI of that program(s) in the comments.	Not Completed ▾	
All providers are considered for the Beneficiary Monitoring Program. Do you object to this participation?	Not Completed ▾	
Have you completed American Pharmacists Assoc's Delivering Medication Therapy Mgmt Services or program approved by Accreditation Council of Pharmacy Education? If yes, then enter what you have completed.	Not Completed ▾	

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- Answer the questions in the Provider Checklist as appropriate
- Add Comments when necessary
- Click Save
- Click Close



Application ID: 20171115618358

Name: Tester, Test

Close

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/15/2017	11/15/2017	Complete	
Step 2: Add Locations	Required	11/15/2017	11/15/2017	Complete	
Step 3: Add Specialties	Required	11/15/2017	11/15/2017	Complete	
Step 4: Associate Billing Provider	Optional	11/15/2017	11/15/2017	Complete	
Step 5: Add License/Certification/Other	Required	11/15/2017	11/15/2017	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	11/15/2017	11/15/2017	Complete	
Step 7: Associate Billing Agent	Optional	11/15/2017	11/15/2017	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	11/15/2017	11/15/2017	Complete	
Step 9: Add Taxonomy Details	Required	11/15/2017	11/15/2017	Complete	
Step 10: Associate MCO Plan	Optional	11/15/2017	11/15/2017	Complete	
Step 11: 835/ERA Enrollment Form	Optional	11/15/2017	11/15/2017	Complete	
Step 12: Upload Documents	Optional	11/15/2017	11/15/2017	Complete	
Step 13: Complete Enrollment Checklist	Required	11/15/2017	11/15/2017	Complete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Go Page Count SaveToXLS

Viewing Page: 1

First Prev Next Last

- Step 13 is complete
- Click on Step 14: Submit Enrollment Application for Approval

(Please Note: If you chose not to complete optional steps you can still submit your application)

You must complete step 14 to submit your application



My Inbox ▾

Provider ▾



Note Pad

External Links ▾

★ My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Close

Next



Final Submission



Application ID: 20171115618358

EnrollmentType: Individual/Sole Proprietor

The information submitted for enrollment shall be verified and reviewed by the State.

During this time, any changes to the information shall not be accepted.

I agree that the information submitted as a part of the application is correct (Private and Confidential).



Application Document Checklist



Forms/Documents

Special Instructions

Source

Required



No Records Found !

- Final Submission: Click Next

Application ID: 20171115618358

Name: Tester, Test

 After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.**Medical Assistance Provider Enrollment & Trading Partner Agreement - Conditions**

In applying for enrollment as a provider or trading partner in the Medical Assistance Program (and programs for which the Michigan Department Of Health and Human Services (MDHHS) is the fiscal intermediary), I represent and certify as follows:

1. The applicant, and the employer (if applicable), certify that the undersigned has/have the authority to execute this Agreement.
2. Enrollment in the Medical Assistance Program does not guarantee participation in MDHHS managed care programs nor does it replace or negate the contract process between a managed care entity and its providers or subcontractors.
3. All information furnished on this Medical Assistance Provider Enrollment & Trading Partner Agreement form is true and complete.
4. The providers and fiscal agents of ownership and control information agree to provide proper disclosure of provider's owners and other persons criminal related to Medicare, Medicaid or Title XX involvement. [42 CFR 455.100]
5. The applicant and the employer agree to provide proper disclosure of any criminal convictions related to Medicare (Title XVIII), Medicaid (Title XIX), and other State Health Care Programs (Title V, Title XX, and Title XXI) involvement since the inception of Medicare, Medicaid, or Title XX programs. [42 CFR 455.106 and 42 U.S.C. § 1320a-7]
6. I agree to read the Medicaid Provider Manual from the Michigan Department Of Health and Human Services (MDHHS). I also agree to comply with 1) the terms and conditions of participation noted in the manual, and 2) MDHHS's policies and procedures for the Medical Assistance Program contained in the manual, provider bulletins and other program notifications.
7. I agree to comply with the provisions of 42 CFR 455.104, 42 CFR 455.105, 42 CFR 431.107 and Act No. 280 of the Public Acts of 1939, as amended, which state the conditions and requirements under which participation in the Medical Assistance Program is allowed.
8. I agree to comply with the requirements of Section 6032 of the Deficit Reduction Act of 2005, codified at section 1902 (a)(68) of the Social Security Act which relates to the conditions and requirements of "Employee Education About False Claims Recovery."
9. I agree that, upon request and at a reasonable time and place, I will allow authorized state or federal government agents to inspect, copy, and/or take any records I maintain pertaining to the delivery of goods and services to, or on behalf of, a Medical Assistance Program beneficiary. These records also include any service contract(s) I have with any billing agent/service or service bureau, billing consultant, or other healthcare provider.
10. I agree to include a clause in any contract I enter into which allows authorized state or federal government agents access to the subcontractor's accounting records and other documents needed to verify the nature and extent of costs and services furnished under the contract.
11. I understand that the incentive payment requested using my National Provider Identifier (NPI) number will be made directly to the Tax ID Number (TIN) that was indicated during the registration process.
12. I am not currently suspended, terminated, or excluded from the Medical Assistance Program by any state or by the U.S. Department of Health and Human Services.

- Read through the entire list of Terms and Conditions

Application ID: 20171115618358

Name: Tester, Test

 After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.

payers. The Trading Partner agrees to defend, indemnify, and hold harmless MDHHS, its Trading Partners, officers, agents, employees, assigns and successors from and against any and all claims, losses, and actions, including all costs and reasonable attorney fees, arising out of electronic Transactions the Trading Partner submits to MDHHS.

6. Standard Transactions.

All Standard Transactions, as defined by HIPAA, will be conducted by the parties using only code sets, data elements, and formats specified by the Transaction Rules and instructions in the MDHHS Companion Guides. The parties agree that when conducting Standard Transactions, they will not change the definition, data condition, or use of a data element or segment in a standard, add data elements or segments to the maximum defined data set, use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specifications.

7. Testing.

All new Trading Partners will cooperate with MDHHS upon request in testing processes prior to submission of production data. Existing Trading Partners will cooperate with MDHHS upon request in testing processes for any changes in submission format prior to submission of production files. MDHHS will notify the Trading Partner of the effective date for production data after successful testing.

8. Data and Network Security.

The parties agree to use reasonable security measures to protect the integrity of data transmitted under this Agreement and to protect this data from unauthorized access. The Trading Partner shall comply with MDHHS data and network security requirements, which may change from time to time and as may be required by the HIPAA security regulations.

9. Automatic Amendment for Regulatory Compliance.

This Agreement will automatically be amended to comply with any final regulation or amendment to a final regulation adopted by the U.S. Department of Health and Human Services concerning the subject matter of this Agreement upon the effective date of the final regulation or amendment.

10. Miscellaneous.

Provisions 3 and 8 shall survive termination of this Agreement.

The Trading Partner will notify MDHHS of any changes in trading partner information supplied including, but not limited to, the name of the service bureau, billing service, recipient of remittance file, or provider code at least 30 calendar days prior to the effective date of such change.

☒ By checking this, I certify that I have read and that I agree and accept the enrollment conditions in the Medical Assistance Provider Enrollment & Trading Partner Agreement.

- Check the box at the end to agree to the Terms and Conditions
- Click Submit Application



My Inbox ▾

Provider ▾



Note Pad

External Links ▾

★ My Favorites ▾

Print

Help

MyInbox > New Enrollment > Individual Enrollment

Application ID: 20171115618358

Name: Tester, Test

Your Application Number 20171115618358 has been successfully submitted for State review. Return with this application number to track the status of your application. ✕

Close

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/15/2017	11/15/2017	Complete	
Step 2: Add Locations	Required	11/15/2017	11/15/2017	Complete	
Step 3: Add Specialties	Required	11/15/2017	11/15/2017	Complete	
Step 4: Associate Billing Provider	Optional	11/15/2017	11/15/2017	Complete	
Step 5: Add License/Certification/Other	Required	11/15/2017	11/15/2017	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	11/15/2017	11/15/2017	Complete	
Step 7: Associate Billing Agent	Optional	11/15/2017	11/15/2017	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	11/15/2017	11/15/2017	Complete	
Step 9: Add Taxonomy Details	Required	11/15/2017	11/15/2017	Complete	
Step 10: Associate MCO Plan	Optional	11/15/2017	11/15/2017	Complete	
Step 11: 835/ERA Enrollment Form	Optional	11/15/2017	11/15/2017	Complete	
Step 12: Upload Documents	Optional	11/15/2017	11/15/2017	Complete	
Step 13: Complete Enrollment Checklist	Required	11/15/2017	11/15/2017	Complete	
Step 14: Submit Enrollment Application for Approval	Required	11/15/2017	11/15/2017	Complete	

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

- Step 14 is now complete and the application has been submitted to the State for review
- Take note of your Application ID for further tracking
- Click Close

(Please Note: Optional steps may show as incomplete if you chose not to complete. This is ok.)

Track Existing Application

How to track a submitted application within CHAMPS

CHAMPS

Provider ▾

PROVIDER ENROLLMENT

- New Enrollment ☆
- Track Application ☆

New Enrollment	Enroll As A New Provider
Track Application	Track Existing Provider Application

- Select Provider tab
- Click Track Application

Close

Next



Track Existing Application



Please provide the Application ID to track your application.

Application ID: *

Request Access to Home Help Provider Info



Click the below link if you are an Existing Home Help Individual or Agency accessing CHAMPS system for the first time. provide the Application ID to track your application.

[Home Help Providers requesting access to their Information.](#)

- Fill in Application ID
- Click Next



My Inbox ▾

Provider ▾



Note Pad

External Links ▾

★ My Favorites ▾

Print

Help

Home > Provider Portal > Track Application

Close

Submit



Verify Application Details



For Additional security, please enter following information:

SSN: *

Date Of Birth:  *

Home Zip Code: *

- Complete all fields marked with an asterisk (*)
- Click Submit

Application ID: 20171115618358

Name: Tester, Test

Your application is currently In-Review by the Provider Enrollment Unit. You cannot make any modifications to your enrollment information at this time.

Close

Enroll Provider - Individual

Business Process Wizard - Provider Enrollment (Individual). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	11/15/2017	11/15/2017	Complete	
Step 2: Add Locations	Required	11/15/2017	11/15/2017	Complete	
Step 3: Add Specialties	Required	11/15/2017	11/15/2017	Complete	
Step 4: Associate Billing Provider	Optional	11/15/2017	11/15/2017	Complete	
Step 5: Add License/Certification/Other	Required	11/15/2017	11/15/2017	Complete	
Step 6: Add Mode of Claim Submission/EDI Exchange	Required	11/15/2017	11/15/2017	Complete	
Step 7: Associate Billing Agent	Required	11/15/2017	11/15/2017	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	11/15/2017	11/15/2017	Complete	
Step 9: Add Taxonomy Details	Required	11/15/2017	11/15/2017	Complete	
Step 10: Associate MCO Plan	Optional	11/15/2017	11/15/2017	Complete	
Step 11: 835/ERA Enrollment Form	Optional	11/15/2017	11/15/2017	Complete	
Step 12: Upload Documents	Required	11/15/2017	11/15/2017	Complete	
Step 13: Complete Enrollment Checklist	Required	11/15/2017	11/15/2017	Complete	
Step 14: Submit Enrollment Application for Approval	Required	11/15/2017	11/15/2017	Complete	

View Page: 1 Go Page Count SaveToXLS

Viewing Page: 1

« First < Prev > Next » Last

- Confirmation your Provider Enrollment Application has been submitted and is being reviewed by the state
- Click Close

Provider Enrollment Final Steps

- Please allow the State time to review the Provider Enrollment Application.
- After the State has looked over the Provider Enrollment Application Providers will receive a letter letting them know whether they have been approved or denied.
 - Letter is sent to the Correspondence address provided in the Provider Enrollment Application.

Provider Resources

- **MDHHS website:** www.michigan.gov/medicaidproviders
- **We continue to update our Provider Resources, just click on the links below:**
 - [Listserv Instructions](#)
 - [Medicaid Alerts and Biller “B” Aware](#)
 - [Quick Reference Guides](#)
 - [Update Other Insurance NOW!](#)
 - [Medicaid Provider Training Sessions](#)
- **Provider Enrollment:**
 - ProviderEnrollment@Michigan.gov or 1-800-292-2550

Thank you for participating in the Michigan Medicaid Program